☐ **APPROVED**
☐ Denied: Reason Code
☐ Returned/ Incomplete
RTN:

NETSPAP STANDING PRIOR APPROVAL FORM

ALL BLANKS MUST BE ACCURATELY COMPLETED. FORMS SENT TO FIRST TRANSIT MUST HAVE SENDER'S NAME OR FAX NUMBER PRINTED AT THE TOP OF EACH TRANSMITTED PAGE.

First Transit
799 Roosevelt Rd, Bldg 4, Suite 200
Glen Ellyn, Illinois 60137
www.netspap.com
(866) 503-9040 Toll Free
(312) 327-3854, (312) 327-3855 Fax
MEDICAL REVIEW MANAGEMENT

Requesting Organization Information

Your Organization Name _____ Date & Time You Initiated Request _____ A.M. P.M.

Your Name _____ Title/Relationship _____

Fax Number _____ Your Phone Number _____

Physician Name _____ Phone Number _____

Participant Information

Participant Name: _____ Recipient Identification Number _____
(Last) (First) (RIN)

Trip Information

New Trip ☐ ***Renewal*** ☐

_____ Beginning Dates _____ Ending Dates
(All services can only be approved for a period up to 6 months).

☐ Dialysis | ☐ Chemotherapy | ☐ Behavioral Health Services | ☐ Radiation Therapy | ☐ Physical Therapy | ☐ Speech Therapy | ☐ Occupational Therapy

☐ Other _____

Appointment Days

Appointment Time _____ If appointment times vary, put an estimated time

Mon	***Tue***	***Wed***	***Thu***	***Fri***	***Sat***	***Sun***
☐	☐	☐	☐	☐	☐	☐

If days **vary**. Please indicate the total trips per week: _____

Origin – Destination Information

Origin Location Name _____ Phone Number _____

Participant's Pick-up Address _____

Pick-up City _____ County _____ State _____ Zip Code _____

Medical Provider Name _____ Most Direct Number to validate appointment _____

Destination Location Name _____

Drop-off Location Address _____

Drop-off City _____ County _____ State _____ Zip Code _____

Non-Emergency Transportation (NET) Provider

Company Name _____ Phone Number _____

Category of Service

(The Category of Service must meet the medical needs of the participant at the most appropriate economic level.)

☐ **Private Auto**

☐ **Fixed Route** (Bus/Train)

☐ **Service Car** ☐ **Taxi**
_____ Non-Employee Attendant
_____ Employee Attendant

☐ **Medicar**
_____ Wheelchair _____ Stretcher
_____ Non-Employee Attendant
_____ Employee Attendant

☐ **Non-Emergency Ambulance**
_____ BLS
_____ ALS
_____ Oxygen/Supplies

Reason for Trip Detailed

(Please provide the Primary and Secondary Diagnosis, Current Treatment Plan and any other pertinent Information)

Agreement and Signature

I understand if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify, under penalty of perjury, that I have obtained the information on this form from the participant (or his or her representative), and the information provided is accurate to the best of my knowledge.

_____ _____
Requesting Person's Signature (Must match requesting person above) Date Signed